

# Group Life Insurance Enrollment

**MINNESOTA LIFE**

Minnesota Life Insurance Company - A Securian Company  
400 Robert Street North • B2-4930 • St. Paul, Minnesota 55101-2098

**EMPLOYER NAME: State of Arkansas**

**POLICY NUMBER: 33432**

**RETURN COMPLETED FORM TO MINNESOTA LIFE**

## EMPLOYEE INFORMATION

|                |                        |           |   |  |
|----------------|------------------------|-----------|---|--|
| First name     | Middle initial         | Last name | Member/Employee #   |  |
| Email address  |                        |           |   |  |
| Street address | City                   | State     | Zip code  |  |
| Date of birth  | Social Security number |           | Gender<br><input type="checkbox"/> Male <input type="checkbox"/> Female |  |
| Agency name    | Agency code            |           | Date of hire  |  |

## BASIC LIFE COVERAGE (\$10,000 coverage PAID for by the state of AR)

I hereby apply for the following Basic Life coverage (if not currently enrolled)

- Employee \$10,000 (paid for by state of AR)       Legislators and Constitutional Officers \$10,000 (paid for by state of AR)       Legislators and Constitutional Officers Basic Life of \$30,000
- Declination - I do not wish to participate/continue under the State Employees' Group Life plan. I understand that I will have to furnish proof of good health if I apply at a later date.

## SUPPLEMENTAL LIFE COVERAGE

**For Employees, Legislators and Constitutional Officers**

I hereby apply for \$\_\_\_\_\_ (\$1,000 increments)

Active Legislators and Constitutional Officers maximum = \$50,000. All other active employees maximum = \$250,000.

**For Dependents of Employees**

Unit(s)/Insurance amount

- 1 unit - \$4,000     3 units - \$12,000     5 units - \$20,000  
 2 units - \$8,000     4 units - \$16,000

**For Dependents of Legislators and Constitutional Officers**

Unit(s)/Insurance amount

- 1 unit - \$20,000     2 units - \$40,000

## SPOUSE AND CHILDREN INFORMATION (Complete if applying for dependent coverage.)

List ALL dependents to be covered for one or more unit(s) of Dependent Life Insurance. Dependents NOT listed will not have coverage.

| Person proposed for insurance - Name (last, first, middle initial) | Relationship | Date of Birth |
|--|--------------|---------------|
|  |              |               |

## AUTHORIZATION

I authorize my employer to withdraw premiums from my salary to pay for employee-paid insurance coverage.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

|                                |                          |                          |             |
|--------------------------------|--------------------------|--------------------------|-------------|
| Employee signature<br><b>X</b> | Daytime telephone number | Evening telephone number | Date signed |
|--------------------------------|--------------------------|--------------------------|-------------|